Physician Documentation — *Willis Knighton Bossier Health Center*

Name: A[redacted] H[redacted]
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 02/10/2018 **Time:** 07:24
Bed .HB1

MRN: 1116206
Account#: B30036697651
Private MD:

HPI:

02/10 08:29 This 4 yrs old Black/African Am Female presents to ED via EMS Ground with complaints of CPR. jjh

08:29 Preceding the arrest, the patient was dyspneic. The arrest occurred at work. Pre-hospital course: The arrest was witnessed by family. Bystanders at the scene did not perform CPR. EMS care prior to arrival: initiation of ACLS, peripheral IV, oxygen, 5 minutes elapsed prior to ACLS. ACLS has been in progress for 20 minutes. ACLS details: Initial rhythm was PEA. The presenting rhythm is PEA. Medications given by EMS prior to arrival - Epinephrine IV x 3 doses, Response to therapy: return of pulse, however lost on arrival to ED. The patient has not experienced similar symptoms in the past. jjh

Historical:

- **Allergies:** Codeine Sulfate; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Nebulizer
  2. dulera
  3. Singulair 5 mg PO chew 1 tabs once daily
- **PMHx:** Asthma

Historical:

07:37 Family history: Unable to obtain family history due to patient is on ventilator. Immunization history: Childhood immunizations behind by unknown time. rmp

08:29 The history from nurses notes was reviewed and confirmed. jjh

ROS:

08:29 ROS as in the HPI, and all other systems were reviewed negative, or noncontributory, except as mentioned below. **Respiratory:** Positive for cough, dyspnea on exertion, hemoptysis, orthopnea, shortness of breath. **Respiratory:** Positive for information from Mom and Grandmother. ROS as in the HPI, and all other systems were reviewed negative, or noncontributory. jjh

08:41 **Cardiovascular:** Positive for unknown. jjh

Exam:

08:29 jjh

Constitutional: The patient appears CPR in progress.
Head/face: Exam is negative for battle signs, raccoon eyes, otorrhea, rhinorrhea, obvious evidence of injury or deformity.
Eyes: Periorbital structures: appear normal, Pupils: are fixed and dilated.
Neck: External neck: is nomal, JVD: is not appreciated, Thyroid: appears normal, Trachea: is midline with no obvious abnormalities.
Cardiovascular: Rhythm is PEA Pulses: none, Heart sounds: Edema: is not appreciated.
Respiratory: BVM, Respirations: none, Breath sounds: decreased breath sounds, that are severe.

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
07:32	86 / 50	147	14 Assisted			15 kg / 33 lbs 1 oz		rmp
07:33					98% on 100% BVM			rmp
07:35	86 / 44	141	14 Assisted		98% on 100% BVM			rmp

Print Time: 2/11/2018 12:04:24

*** CHART COMPLETE ***

EXHIBIT 4 tabbies

Physician Documentation Con't.

07:41	90 / 46	141	14 Assisted		100% on 100% BVM			rmp
07:46	85 / 51	135	14 Assisted		100% on 100% BVM			rmp
07:55					83% on 15 lpm ETT ambu			rmp
08:04	115 / 72	155	14 Assisted		100% on 15 lpm ETT ambu			rmp

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
07:27	none(1)	none(1)	none(1)		3	rmp
08:29	none(1)	none(1)	none(1)		3	jjh

Procedures:

08:29 Endotracheal intubation: Pre procedure oxygenation with 100% O2 with Ambu Bag assisted ventilation. Intubated orally using the GlideScope video laryngoscope, with 5.0 mm ETT. Successful on second attempt. Ventilated post procedure with Ambu bag and ET tube with 100% O2. Placement verified by chest X-ray, CO2 detector w/ + color change, auscultating bilateral breath sounds, O2 saturation after procedure was 100 %. Patient tolerated well. CPR: Initial patient assessment: CPR in progress The presenting cardiac rhythm is PEA. respirations assisted with BVM, Compressions: began prior to arrival. Meds given: See Meds list. regained rhythm. Limited bedside ultrasound performed by me; Cardiac exam: there are findings consistent with wall motion. jjh

MDM:

08:29 jjh

Differential diagnosis: arrythmia, cardiac arrest, respiratory arrest.
Data reviewed: vital signs, nurses notes, lab test result(s), radiologic studies, plain films, and as a result, I will administer steroids, administer nebulizer.
Data interpreted: Pulse oximetry:.
Counseling: I had a detailed discussion with the patient and/or guardian regarding: the historical points, exam findings, and any diagnostic results supporting the discharge/admit diagnosis, lab results, radiology results, the need to transfer to another facility, emergently.
Medication response: The patient's symptoms have improved.
Response to treatment: the patient's symptoms have markedly improved after treatment.
Physician consultation: Dr. Minh Tran MD was called at 07:45, was contacted at 07:50, regarding transfer, accepts patient in transfer consult, patient's condition, and will see patient in unit.

08:43 Patient medically screened. jjh

09:31 jjh

Special discussion: Nursing staff noted small amount of blood before placing foley. Blood apparently noted in vaginal area.

Order	Status	Time	By	For
EPINEPHrine 1.7 mL Intraosseous in right tibial tuberosity once	Ordered	02/10/18 07:26	rmp	jjh
	Administered	02/10/18 07:26	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Physician Documentation Con't.

Drug alert over ride reasons: MD discretion

02/10/18 07:26 **Administered:** EPINEPHrine 1.7 mL Intraosseous in right tibial tuberosity rmp

02/10/18 08:23 **Follow Up:** Response: Cardiac Rhythm changed rmp

Order	Status	Time	By	For
DOPamine 3 mcg/kg/min IVPB titrate 1 mcg/kg/min q 10 min; goal SBP >90, Max dose 20 mcg/kg/min	Ordered	02/10/18 07:32	rmp	jjh
	Canceled	02/10/18 07:35	Richard, Pool	
Notes:	**Order Method:** Verbal - Read back			
	Sign off:			

Reason for Cancellation: Duplicate Order

Order	Status	Time	By	For
DOPamine 2 mcg/kg/min IVPB titrate 1 mcg/kg/min q 10 min; goal SBP >90, Max dose 20 mcg/kg/min **Computed Dose:** 30 mcg/min	Ordered	02/10/18 07:35	rmp	jjh
	Administered	02/10/18 07:36	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

02/10/18 07:36 **Administered:** DOPamine 2 mcg/kg/min IVPB in right antecubital rmp

02/10/18 08:23 **Follow Up:** Response: Blood pressure is improved; IV Status: Infusion discontinued rmp

Order	Status	Time	By	For
RT Hand Nebulizer Rx Order	Ordered	02/10/18 07:40	rmp	jjh
	Completed	02/10/18 07:40	Dispatcher MedHost	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

FREQUENCY: (OERTFREQ): X3

Priority OTH: Stat

DOSAGE/MEDICATION: (OERTDOSMED): Albuterol 1 unit dose

Order	Status	Time	By	For
CBC With Diff	Ordered	02/10/18 07:41	rmp	jjh
	Reviewed	02/10/18 08:28	John Horan	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Collected by Nurse? (No - Change to Yes for Nurse Collect): No

Ordering Location: ERBPC100.1

Priority LAB: Stat

Quantity 1: 1

Order	Status	Time	By	For
Chem 8	Ordered	02/10/18 07:41	rmp	jjh
	Reviewed	02/10/18 08:28	John Horan	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Collected by Nurse? (No - Change to Yes for Nurse Collect): No

Ordering Location: ERBPC100.1

Priority LAB: Stat

Physician Documentation Con't.

Quantity 1: 1

Order	Status	Time	By	For
ABG	Ordered	02/10/18 07:41	rmp	jjh
	Reviewed	02/10/18 08:28	John Horan	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Collected by Nurse? (No - Change to Yes for Nurse Collect): No

Ordering Location: ERBPC100.1

Priority LAB: Stat

Quantity 1: 1

Order	Status	Time	By	For
Chest Xray Portable 1 View	Ordered	02/10/18 07:41	rmp	jjh
	Reviewed	02/10/18 09:58	John Horan	
Notes: Bed Name: 3	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Is the patient able to bear weight? (OERDBEARWT):

Is the patient at risk for falls? (OERDFALLS):

MODE OF TRANSPORTATION : (OERDTRANS): Stretcher

O2: (OEADO2): No

Priority RAD: Stat

REASON FOR EXAM: (OERDEXAM): CPR

SPECIFIC TIME TO BE DONE: (OERDSPECTI): STAT

WEIGHT? : (OERDWEIGHT): 15

ER EXAM ROOM/BED: (OERDERRMBD): 3

Order	Status	Time	By	For
Foley to Gravity	Ordered	02/10/18 07:41	rmp	jjh
	Completed	02/10/18 08:03	Richard Pool	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Order	Status	Time	By	For
NG Tube	Ordered	02/10/18 07:41	rmp	jjh
	Completed	02/10/18 08:03	Richard Pool	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

Order	Status	Time	By	For
Solu-MEDROL 30 mg IVP once	Ordered	02/10/18 07:43	rmp	jjh
	Administered	02/10/18 07:46	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			

02/10/18 07:46 **Administered:** Solu-MEDROL 30 mg IVP in right antecubital rmp

02/10/18 08:22 **Follow Up:** Response: Respiratory status improved rmp

Order	Status	Time	By	For

Physician Documentation Con't.

Terbutaline 10 mcg/kg Sub-Q in right lower abdomen once; not to exceed 0.4 milligram	Ordered	02/10/18 08:02	rmp	jjh
	Administered	02/10/18 08:02	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			
02/10/18 08:02 **Administered:** Terbutaline 10 mcg/kg Sub-Q in right lower abdomen				rmp
02/10/18 08:22 **Follow Up:** Response: Respiratory status improved				rmp

Order	Status	Time	By	For
RT Hand Nebulizer Rx Order	Ordered	02/10/18 08:02	rmp	jjh
	Completed	02/10/18 08:02	Dispatcher MedHost	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			
FREQUENCY: (OERTFREQ): X3				
Priority OTH: Stat				
DOSAGE/MEDICATION: (OERTDOSMED): Racemic EPI				

Order	Status	Time	By	For
NS 0.9% 20 mL/kg IV at Bolus once **Computed Dose:** 300 mL	Ordered	02/10/18 08:02	rmp	jjh
	Administered	02/10/18 08:02	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off: Horan, John, MD 02/10/18 08:43			
02/10/18 08:02 **Administered:** NS 0.9% 20 mL/kg IV at Bolus in right antecubital				rmp
02/10/18 08:22 **Follow Up:** IV Status: Infusion continued upon Admission				rmp

Order	Status	Time	By	For
Sodium Bicarbonate 16.7 mL Intraosseous in right tibial tuberosity once	Ordered	02/10/18 14:57	rmp	jjh
	Administered	02/10/18 07:28	rmp	
Notes:	**Order Method:** Verbal - Read back			
	Sign off:			
02/10/18 07:28 **Administered:** Sodium Bicarbonate 16.7 mL Intraosseous in right tibial tuberosity				rmp

Order Signatures:

Horan, John, MD MD jjh Pool, Richard, RN RN rmp

ECG:

09:42 Rate is 143 beats/min. Rhythm is regular, Sinus tachycardia with No ectopy. QRS Axis is Normal. PR interval is normal. QRS interval is normal. QT interval is normal. No Q waves. T waves are Normal. No ST changes noted. Clinical impression: Abnormal EKG without significant change and Sinus tachycardia. Interpreted by me. jjh

Disposition:

08:41 Electronically signed by: John J. Horan MD. jjh

Disposition:

02/10/18 08:43 Transfer ordered to WK-South. Diagnosis are Respiratory arrest, Cardiac arrest.

- Reason for transfer: Emergency transfer.
- Accepting physician is Tran.

Physician Documentation Con't.

- Condition is Stable.
- Problem is new.
- Symptoms have improved.

Critical Care Time Excluding Procedures:

08:41 Critical care time: Consultation: 10 minutes, Family Intervention: 10 minutes, Patient Care: 60 minutes, Documentation: 10 minutes. Total time: 90 minutes jjh

Signatures:

Dispatcher MedHost		EDMS	Horan, John, MD	MD	jjh
Pool, Richard, RN	RN	rmp			

Corrections:

07:35 ~~07:32~~ ~~DOPamine 3 mcg/kg/min IVPB titrate 1 mcg/kg/min q 10 min; goal SBP >90, Max dose 20 mcg/kg/min ordered.~~ ~~rmp~~ rmp

Nurse's Notes

Name: A[redacted] H[redacted]
Age: 4 yrs **Sex:** Female **DOB:** 10/01/2013
Arrival Date: 02/10/2018 **Time:** 07:24
Bed .HB1

Willis Knighton Bossier Health Center

MRN: 1116206
Account#: B30036697651
Private MD:

Presentation:

02/10 07:24 Method of Arrival: EMS Ground. rmp

07:24 Person Transporting: Shreveport FD EMS. CPR Care Prior to arrival: chest compressions provided manually by EMS crew members bag-valve-mask ventilation, Medications: Epinephrine Sodium bicarbonate epi x 3, 1 bicarb. The event was unwitnessed, unknown symptoms. The patient's initial cardiac rhythm was PEA. rmp

07:27 Preferred language for medical communication is English. Presenting complaint: EMS states: Pt found down this mon ring, went to WKS last night for breathing difficulty and d/c's home. Transition of care: patient was not received from another setting of care. Mechanism of Injury: denies injury. rmp

07:28 Acuity: 1 - Resuscitation. rmp

08:26 The event was a witnessed respiratory arrest at or about 06:51. rmp

Triage Assessment:

07:27 **General:** Appears Unresponsive Behavior is Unresponsive. **Pain:** Denies pain. rmp

Historical:

- **Allergies:** Codeine Sulfate; FISH PRODUCT DERIVATIVES;
- **Home Meds:**
  1. Albuterol Nebulizer
  2. dulera
  3. Singulair 5 mg PO chew 1 tabs once daily
- **PMHx:** Asthma

Historical:

07:37 Family history: Unable to obtain family history due to patient is on ventilator. Immunization history: Childhood immunizations behind by unknown time. rmp

08:29 The history from nurses notes was reviewed and confirmed. jjh

Screening:

07:27 **Abuse screen:** rmp
Unable to obtain physical abuse screening due to patient is on ventilator.
Patient fall risk assessment;
No risks identified.
Learning Barriers:
decreased level of consciousness.
Exposure risk/Travel Screening:
No exposures identified.

Assessment:

07:24 **CPR initial assessment:** unresponsive, cardiac monitor rhythm showing bradycardia pupils fixed & dilated, pale. **CPR recorder notes:** CPR Started: 07:25 bag-valve-mask ventilation. rmp

07:28 **CPR recorder notes:** CPR stopped: 07:28. rmp

07:28 **CPR initial assessment:** cardiac monitor rhythm showing sinus tach. **CPR recorder notes:** CPR stopped: return of spontaneous circulation, critical care support continued. rmp

08:27 **Pain:** level that is acceptable is 0 out of 10 on a pain scale. rmp

Vital Signs:

Time	B/P	Pulse	Resp	Temp	Pulse Ox	Weight	Pain	Staff
07:32	86 / 50	147	14 Assisted			15 kg / 33 lbs 1 oz		rmp
07:33					98% on 100% BVM			rmp
07:35	86 / 44	141	14 Assisted		98% on 100% BVM			rmp

Nurse's Notes Con't

07:41	90 / 46	141	14 Assisted		100% on 100% BVM			rmp
07:46	85 / 51	135	14 Assisted		100% on 100% BVM			rmp
07:55					83% on 15 lpm ETT ambu			rmp
08:04	115 / 72	155	14 Assisted		100% on 15 lpm ETT ambu			rmp

Vitals:

07:27 Emergency Severity Index Calculation; meets ESI level 1 acuity, life saving interventions immediately needed. rmp

07:27 Acuity: 1 - Resuscitation. rmp

07:39 ETCO2 23 mmHg. rmp

Glasgow Coma Score:

Time	Eye Response	Verbal Response	Motor Response	Modifying Factors	Total	Staff
07:27	none(1)	none(1)	none(1)		3	rmp
08:29	none(1)	none(1)	none(1)		3	jjh

ED Course:

07:24 Patient arrived in ED. rmp

07:24 Patient moved to . rmp

07:24 Patient moved to 3. rmp

07:24 IV maintenance: IV/IO access was obtained by EMS prior to arrival in ER, Dressing intact. Gauge & site: right tibial tuberosituy. rmp

07:24 Cardiac monitor, Pulse oximetry, Non invasive blood pressure, End Tidal CO2, monitor alarms on and audible. Crash cart at the bedside LifePack monitor/defibrillator with defib pads applied. rmp

07:28 Triage completed. rmp

07:29 Nasogastric tube inserted successfully, 10 Fr. via right nare. to continuous suction. rmp

07:33 Insertion site prepared per hospital policy and procedure, Inserted peripheral venous access catheter, 22 gauge, in right antecubital area primed needleless intermittent infusion extension set attached, flushed with 2 ml normal saline. rmp

07:40 Family updated on plan of care. Family Grandmother stated pt woke up around 7 and was having respiratory distress, attempted to give home neb, pts' lips turned blue then pt went unresponsive and 911 activated. rmp

07:44 Intubation: Ventilated with 100% NRB prior to procedure. O2 saturation prior to procedure was 100 %. with 5.0 Fr. ETT. placed orally. Performed by John Horan MD Attempts were not successful. Ventilated with Ambu bag. rmp

07:47 No procedures done that require assistance. Foley cath inserted with sterile technique, 8 Fr. to gravity drainage. Catheter secured with Stat Lock device. urine meter applied. Urine specimen collected. by Stephanie Jaeger, RN returned amber urine. bulb inflated with 5 cc sterile water Patient tolerated well. rmp

07:50 Intubation: Ventilated with 100% NRB prior to procedure. O2 saturation prior to procedure was 100 %. with 5.0 Fr. ETT. placed orally. Performed by John Horan MD Successful on second attempt. Placement verified by CXR, CO2 detector w/ + color change, auscultating bilateral breath sounds, Ventilated with Ambu bag. rmp

Nurse's Notes Con't

07:51 bicarb 16.5 ML given IO. rmp
08:05 BCFD dispatch notified of 911 transfer. They are sending a trauma unit over now. ns2
08:08 Pool, Richard, RN is Primary Nurse. rmp
08:11 Changed ETT pulled back 1 cm. Now 15 cm at the lip. ns2
08:11 Portable x-ray done. ns2
08:23 Transfer consent explained by physician, ordered by John Horan MD signed by two RNs, family unavailable. rmp
08:25 Horan, John, MD is Attending Physician. jjh
08:36 Patient moved to .HB1. rmp

Administered Medications:

Time	Drug & Dose *Dispensable & Quantity*	Volume	Route	Rate	Infused Over	Site	Delivery	Staff
07:26	EPINEPHrine 1.7 mL		Intraosseous			right tibial tuberosity		rmp
08:23	Follow up: Response: Cardiac Rhythm changed							rmp
07:28	Sodium Bicarbonate 16.7 mL		Intraosseous			right tibial tuberosity		rmp
07:35	CANCELLED (Duplicate Order): DOPamine 3 mcg/kg/min IVPB titrate 1 mcg/kg/min q 10 min; goal SBP >90, Max dose 20 mcg/kg/min							rmp
07:36	DOPamine 2 mcg/kg/min		IVPB			right antecubital		rmp
08:23	Follow up: Response: Blood pressure is improved; IV Status: Infusion discontinued							rmp
07:46	Solu-MEDROL 30 mg		IVP			right antecubital		rmp
08:22	Follow up: Response: Respiratory status improved							rmp
08:02	Terbutaline 10 mcg/kg		Sub-Q			right lower abdomen		rmp
08:22	Follow up: Response: Respiratory status improved							rmp
08:02	NS 0.9% 20 mL/kg		IV	Bolus		right antecubital		rmp
08:22	Follow up: IV Status: Infusion continued upon Admission							rmp

Outcome:

08:08 Report called to Julie, RN, using the SBAR communication method. rmp
08:27 Transferred to WK-South by EMS ground BCFD T-5 Transfer form completed. Note: with Missy, RN. Discharge instructions given to family, Instructed on admit to floor admission process Demonstrated understanding of instructions, No questions or concerns expressed to me at discharge. **Critical Care visit due to** respiratiory failure. **Medication reconcilliation form provided. Med Effects:** Effects of administered medications were addressed. **Oxygen use:** Oxygen used on this visit. rmp
08:43 ER care complete, transfer ordered by MD. jjh
10:04 Electronic medical record closed. mkg1

Signatures:

Horan, John, MD MD jjh
Pool, Richard, RN RN rmp
Springfield, Brooke, RN RN ns2
Golding, Melissa, RN RN mkg1

Nurse's Notes Con't

Corrections:

07:47	~~07:33~~ ~~Pulse Ox 98% 02 15% BVM;~~	~~rmp~~	rmp
07:47	~~07:35~~ ~~BP 86 / 44; Pulse 141bpm; Resp 14bpm; Assisted; Pulse Ox 98% 02 15% BVM;~~	~~rmp~~	rmp
07:47	~~07:41~~ ~~BP 90 / 46; Pulse 141bpm; Resp 14bpm; Assisted; Pulse Ox 100% 02 15% BVM;~~	~~rmp~~	rmp
07:48	~~07:38~~ ~~Foley cath inserted with sterile technique, silicone, 8 Fr. by tech Stephanie to gravity drainage. Catheter secured with Stat Lock device. urine meter applied. returned bloody urine. bulb inflated with 5 cc sterile water~~	~~rmp~~	rmp
10:02	~~08:27~~ ~~Transferred to WK South by EMS ground BCFD T-5 Transfer form completed.~~	~~rmp~~	mkg1